
# Department of Health Services

# Gap Analysis and Requirements

# Technical Requirements

## SD/MC HIPAA Phase II Project

**October 5, 2004**

**FINAL VERSION**

# Document History (Version Control)

| Version | Date | Author | Brief Description of Modifications |
|---|---|---|---|
| 0.A | Sept. 8, 2004 | Bob Pitvorec | Initial Draft |
| 0.B | Sept. 9, 2004 | Karen Davis | Initial Draft Revisions |
| 0.C | Sept. 9, 2004 | Rick Falls | Initial Draft Revisions |
| 0.D | Sept. 30, 2004 | Bob Pitvorec | Incorporation of Reviewer Edits |
| 1.0 | Oct. 5, 2004 | Bob Pitvorec | Final Revisions |

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# 1 Document Overview

The purpose of this document is to provide a description of the Gap Analysis of the differences between the current technical processes and procedures within the Short Doyle/Medi-Cal (SD/MC) claims and the Health Insurance Portability and Accountability Act (HIPAA), Transactions and Code Sets (TCS) regulations. It also provides a list of desired features in the form of Requirements that take advantage of the HIPAA mandate for an efficient, highly automated and standardized system.

## *1.1 Scope*

The scope of this project is the SD/MC claims processing system that is distributed among three departments: the California Department of Alcohol and Drug Programs (ADP), the California Department of Mental Health (DMH), and the California Department of Health Services (DHS).

The HIPAA TCS GAP Analysis includes the following transactions:

- ASC X12N 837 (I), Health Care Claim – Institutional, Version 4010A1 (004010X096A1)
- ASC X12N 837 (P), Health Care Claim – Professional, Version 4010A1 (004010X098A1)
- ASC X12N 835, Health Care Claim Payment/Advice, Version 4010A1 (004010X091A1)
- ASC X12N 276/277, Health Care Claim Status Request and Response, Version 4010A1 (004010X093A1)

## *1.2 Background*

**Phased Implementation**

### 1.2.1 Phase I

The SD/MC HIPAA Compliance project consists of a phased implementation. The Phase I project is complete. It allowed a partial solution to HIPAA compliance by providing for the receipt of electronic claims through the use of 837 Claim Transactions, the return of a 997 Acknowledgement and the use of the 835 Payment and Remittance Advice Transaction to report adjudication results to submitters. The Phase I project was accomplished through the use of a third-party Translator (See Beyond) housed at the Health and Human Services Data Center (HHSDC) and configured by ADP and DMH. The Translator runs in conjunction with the DMH-developed Information Technology Web Services (ITWS) web site, which is used for a variety of communications between DMH/ADP and the county Mental Health Plans and Alcohol and Other Drug Program Plans (Counties), as well as the ADP Direct Providers.

### 1.2.2 Phase II

The SD/MC Phase II project reflects the DHS Office of HIPAA Compliance (DHS-OHC) project methodology and consists of five phases that are designed to make the SD/MC claim process compliant with the HIPAA TCS Final Rule and Addenda. The five phases are developed in sequence as follows:

- Project Planning,
- Assessment
- Gap Analysis & Requirements
- Design Specifications
- Remediation & Implementation

Project Planning of Phase II is completed and is composed of planning for the overall Phase II project.

DHS has contracted with SAIC and FOX Systems, Inc. (the SAIC/FOX HIPAA Team) to develop the Assessment phase, that is to assess the current processes and procedures for SD/MC claims, and to develop the Gap Analysis & Requirements phase, that is the gap analysis of the differences between the SD/MC claims processes and the requirements of the HIPAA TCS regulations, and to document a set of recommendations that will bring SD/MC into compliance with these requirements.

The SAIC/FOX HIPAA Team completed the assessment phase of this project with the delivery of the Integrated Assessment, Short-Doyle Medi-Cal HIPAA Phase II, August 2004.

The assessment work of Phase II also provides a current Technical Assessment as it relates to the HIPAA TCS regulations. Completed during June 2004, the technical assessment is found in the document, the California Department of Health Services, Technical Assessment, Short Doyle HIPAA Phase II.

The current phase is the GAP Analysis and Requirements, and includes the development of this document, the Technical Requirements of the GAP Analysis and Requirements of Phase II.

### 1.2.3 Methodology

HIPAA-related projects have previously been completed within ADP, DHS and DMH that are relevant to Phase II. The project documents were reviewed initially during the Assessment Phase of the project and again during this phase, the GAP Analysis and Requirements. ADP, DMH and DHS continue to develop and upgrade HIPAA related documents and these documents were also reviewed. Documents were also obtained

from the FOX Systems HIPAA Data Library.

Although many documents were reviewed, the following documents contributed the most relevant information.

- ADP Companion Guide for 837p and 835 Transactions (4/27/2004)
- ADP Procedures for TAPS and the SD/MC Interface
- ADP InfoNet DMC Users Manual (1999)
- HIPAA GAP Analysis Report for ADP (9/26/2003)
- DMH Crosswalk Mappings
- DMH SD/MC Claim File Submission Requirements (for ITWS)
- DMH Procedures for SD/MC Interface
- TCS HIPAA Assessment and GAP Analysis Report for DMH (01/2004)
- Various Documents describing the SD/MC HIPAA Translation
- SD/MC Analysis Document for DMH (09/12/2001)
- DHS Technical Assessment, Short Doyle HIPAA Phase II
- Internal and External Code to X12 Implementation Guides
- Transaction Code Sets Table
- Implementation Guides for HIPAA Transactions
- Various memos and e-mails in support of production processes
- List of tables and scripts that support the ITWS process.
- List of tables and scripts that support the AOD InfoNet and TAPS processes
- Mainframe production Job Logs

In addition to document review, interviews were conducted with staff within ADP, DMH and DHS. The focus of the interviews was to address shortcomings of the overall existing processes, known issues with HIPAA compliance and an exploration of features that could improve the business practices of the various units.

DHS also invited county input by inviting all counties to a day long conference in which issues were discussed that dealt with the existing processes and with the effort to meet HIPAA compliance.

# 2 Existing System's Features Requiring Change to be HIPAA Compliant

The research and meetings resulted in a list of requirements that must be addressed if the SD / MC system is to become HIPAA Compliant. Within this section, the requirements are grouped in categories as follows:

- Current Requirements Compatible with HIPAA – Existing processes that can be implemented in HIPAA without significant changes.
- Current Requirements in Conflict with HIPAA – Existing processes that cannot be implemented in HIPAA as they currently exist. The process must be significantly changed or discontinued. The current process (requirement) is in the "GAP Description."
- New Requirements for HIPAA Compliance – Processes that do not currently exist, but must be implemented to achieve HIPAA compliance.
- Current Requirements Not Covered by HIPAA – Existing processes that may be continued without requiring change due to HIPAA.
- Technical Process Improvement Opportunities – Current processes that could modified or new processes that could be implemented to improve the SD/MC process overall, but are either not required or not covered by HIPAA.

Each Technical Requirement or Improvement Opportunity has been assigned a Unique ID; however, some are also Business requirements. These have their IDs listed within parentheses, implying a technical requirement that is also a business requirement.

The source of each requirement is attached to the requirement and is found in a column titled, "Reference". In order to conserve table space, the sources are abbreviated as follows:

**Table 1 – Requirement Sources**

| Reference Code | Reference Description |
|---|---|
| ABI | ADP Business Interview |
| ATI | ADP Technical Interview |
| MBI | DMH Business Interview |
| MTI | DMH Technical Interview |
| SDTI | DHS Technical Interview |
| CNTY | County Business Interview |
| ADOC | ADP HIPAA Documentation |
| MDOC | DMH HIPAA Documentation |
| SDOC | SD/MC Analysis Document |
| HAAI | ADP Invoice Process Interview |

| | |
|---|---|
| HMAI | DMH Invoice Process Interview |
| RHIP | HIPAA Regulations |

## 2.1 Presentation of Requirements

**Table 2 – Current Requirements Compatible with HIPAA**

| Current Requirements Compatible with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[1]** | **HIPAA Man. / Opt. [2]** | **Issue or Comment** | **Reference** |
| T108 (A1) | Accept claims data from counties and direct providers. | ADP | M | 37 counties (interact with the system, i.e. provide claims data. There are about an equal number of Direct Providers (Note: combine with DMH to get full number of trading partners.) | ATI |
| T114 | In a clinic environment, ADP uses the clinician's initials to look for such things as billing 30-hour days | ADP | O | The counselor's initials are currently extracted from an 837 NM1 segment in Phase I. This can continue or IDs could be assigned. | ABI |
| T117 | Counties may choose to receive Approve & Deny, with no Suspends. | ADP / DMH / DHS | O | HIPAA expects claims to Approve & Deny however it does allow suspense in certain situations | CNTY |
| T119 (C1) | Notify trading partners of suspended claims. | ADP / DMH / DHS | O | There is no HIPAA mandated mechanism for notifying the provider of a suspended claim. The current process can continue or can be modified into a different process if agreeable with trading partners. | RHIP |

[1] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[2] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

| Current Requirements Compatible with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[1]** | **HIPAA Man. / Opt. [2]** | **Issue or Comment** | **Reference** |
| T1AA (E1) | It is critical that the control numbers the provider places on the 837 be returned on the 835. These control numbers are also be used to locate the claim in the 276/277 process. | ADP | M | HIPAA permits the submitter to include tracking number that must be returned on outbound transactions. | ADOC |

**Table 3 – Current Processes in Conflict with HIPAA**

| Current Processes In Conflict with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **HIPAA Requirement Description** | **Req. Org.[3]** | **HIPAA Man. / Opt.[4]** | **GAP Description (Current Process)** | **Reference** |
| T201 (D16) | All monies collected, including Share of Cost (SOC) and encumbered SOC, must be reported in the 837. They may be reported at either the claim or line level but need to be claim specific. | ADP / DMH | M | SOC, TPL and allowances happen but are not reported on a claim level. Any monies they collect are reported on the invoice. | ABI, MBI |
| T202 (B5) | Only HIPAA codes are compliant. Diagnosis must be in the ICD-9 code list | ADP | M | ADP uses a variety of code structures for diagnosis. DSM-IV is their primary diagnosis code set. | ABI |
| T204 (B6) | Other payers are to be reported in the claim when known. | DMH ADP | M | DMH does not receive information on other payers | MBI |
| T208 (F6, B1) | HIPAA mandates the use of the 835, if it is returned to a provider. An EOB file may be produced for internal use, as long as a compliant 835 is returned as the only explanation of the payment. | ADP / DMH | M | Produce two EOB files after adjudication. One is forwarded to ITWS and the other is used to create the ASRs | ATI, MTI |
| T209 | The system must recognize the 837P and the 837I (DMH Only). | ADP / DMH | M | The SD/MC (MSD) process passes a two byte field (formerly unused in the 157 and 350 byte records) to determine that an 837p transaction was originally received and therefore requires an 835 response | ATI, MTI |
| T210 (E20) | A provider may request a paper EOB but its data must resemble the 835 so that no incentive is given to providers to request paper over electronic. | ADP / DMH | M | Counties may receive electronic EOBs, paper EOBs or both, depending upon county request, which is set in a table | ATI, MTI |

[3] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[4] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

| Current Processes In Conflict with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **HIPAA Requirement Description** | **Req. Org.[3]** | **HIPAA Man. / Opt.[4]** | **GAP Description (Current Process)** | **Reference** |
| T213 (B9, D8) | The system needs to implement the 276/277 as an electronic method of claim status request / response that is HIPAA compliant. | ADP DMH | M | Some non-compliant electronic claim status is available. No electronic request / response process exists. | ADOC |
| T214 | ADP needs to use the compliant 835 to provide claim remittance advice and payment information. | ADP DMH | M | ADP is processing claims for services that have already been delivered to patients (the use of the 835 notification only--basically noncompliant--could be done between ADP and the county if the county were a health plan, not a provider) | ADOC |
| T215 | The 835 should only report finalized claims – paid or denied | ADP DMH | M | Suspended claims are on the 835 that is returned to the provider. | ADOC |
| T217 (E25) | The 835 Implementation Guide notes that in the case of a paper check, the check number should be used as the Reassociation Trace Number. The documentation provided with the actual check will need to provide all of the SD/MC Batch Numbers that are being paid from that check. The 835 carries all the information regarding claims associated with the check payment. If the 835 carries the check number then the check number doesn't have to carry the batch or claim information. | ADP | M | Neither the EOB nor Phase I 835 include the check number. | ADOC |

| Current Processes In Conflict with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **HIPAA Requirement Description** | **Req. Org.[3]** | **HIPAA Man. / Opt.[4]** | **GAP Description (Current Process)** | **Reference** |
| T218 (D4) | The system must capture and store links to locate a claim in order to report the status. The 276 Transaction allows the requestor to request information at the claim level or the service line level. It allows a requestor, who does not know the claim number, to provide related information (e.g., beneficiary ID, Date of Service, Procedure Code) so that the payer can find the claim that meets the search criteria and provide status via the 277 | ADP | M | The system has no specific processes in place to locate a claim and report status. | ADOC |
| T219 | Program information built into proprietary codes will need to be derived from other HIPAA data. | ADP | M | ADP requests that transactions of claims submitted in the 837P format, contain the program codes (20 or 25) within the transaction. | ATI |
| T221 (D5) | Eligibility data returned on outbound HIPAA transactions must conform to the rules of the given transaction. Non-HIPAA data may not be returned on an outgoing transaction. | DHS | M | If eligibility is found, the MEDS ID, Client Index Number (CIN), Beneficiary Identification Card (BIC) Issue Date, Health Insurance Claim (HIC) Number, Date of Birth month and year, Buy-In Part B Effective Date, Aid Code, and County Code are added to the claim information | SDOC |
| T222 | Claims should be denied instead of suspended, unless a claim is awaiting an attachment, to support HIPAA compliant processing (i.e., 835, voids, and resubmissions). | DHS | M | Claims are suspended if there is no appropriate Medi-Cal or Healthy Families eligibility for the Date of Service. | SDOC |

| Current Processes In Conflict with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **HIPAA Requirement Description** | **Req. Org.[3]** | **HIPAA Man. / Opt.[4]** | **GAP Description (Current Process)** | **Reference** |
| T223 | If counties are considered health plans, the 820 should be used for payments. Using the 835 for payments would conflict with HIPAA. | ADP | M | SD/MC processes for counties is the same as for Direct Providers | ATI |
| T224 | Payment information in reported electronic format may have to be replaced by the 835. | DHS | M | The Reporting process generates the SD/MC reports, including Approved Claims, Error Correction, Duplicate Error Correction, Provider, and Expenditures. Reports are created in hard copy, fiche, and electronic formats. | SDOC |
| T225 | ECRs that are processed in response to electronic submissions must be changed to HIPAA transactions (837 voids and resubmissions) | ADP / DMH / DHS | M | Suspended claims are corrected by filling out ECRs or ECFs | CNTY |
| T229 (B10, C3,C4) | Use 837P HIPAA Service Code Structure (Procedure code, Units of Measure, Procedure Modifiers 1 & 2, Place of Service, Taxonomy Code) instead of SD/MC Claims Service Codes (Mode of Service, Service Function, Service Description) | DMH ADP | M | SD/MC uses codes that are non-compliant | MDOC |
| T230 (B10, C3,C4) | Use 837I HIPAA Service Code Structure (Revenue Code, Units of Measure, Procedure code, Procedure Modifiers 1 & 2) instead of SD/MC Claims Service Codes (Mode of Service, Service Function, Service Description) | DMH | M | SD/MC uses codes that are non-compliant | MDOC |

| Current Processes In Conflict with HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **HIPAA Requirement Description** | **Req. Org.[3]** | **HIPAA Man. / Opt.[4]** | **GAP Description (Current Process)** | **Reference** |
| T231 | Replace the SD/MC values with 837P / 837I values: Crossover Indicator; Late Billing Override; Claim Adjudication Type; Error Codes; Third Party Liability (TPL); | DMH | M | SD/MC uses codes that are non-compliant | MDOC |
| T236 (B10) | The system must accept and process only HIPAA compliant procedure codes, i.e. HCPCS, CPT, and ICD-9 diagnosis codes. | ADP / DMH / DHS | M | ADP procedure reporting requirements are non compliant | RHIP |
| T2AA | Claims should be received with other payer info completed. If the other party has not been billed, the claim should deny with code relating to payment by other payer. | DHS | M | Claims are suspended if the recipient has Medicare or other health coverage | SDOC |

**Table 4 – New Requirements for HIPAA Compliance**

| New Requirements for HIPAA Compliance | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[5]** | **HIPAA Man. / Opt.[6]** | **GAP Description** | **Reference** |
| T301 (F17) | Provide the ability to back-out or nullify claims that were previously approved. To be compliant, the system must handle voids and resubmissions with revised data content. | ADP | M | The current correction process (ECR) is not HIPAA compliant. | ABI |
| T303 (D1) | Capture rendering provider info that is required on the 837. | ADP / DMH | M | ADP captures counselor's initials only; DMH receive no rendering provider information. | MBI |
| T306 | DMH and ADP must utilize the Transactions Standards including: 837I/ 837P, 276/277 & 835 | DMH ADP | M | DMH and ADP do not utilize the 276/277, and the 837I (DMH) and 835 are not fully compliant. | MDOC |
| T309 | The system needs to manage the maximum number of claims with out a run time impact. System needs to be sized so that projected volumes have no impact. | DHS | M | 200,000 to 600,000 DMH claims are processed per cutoff period. This is not a gap, but is a benchmark for processing requirements. | SDTI |
| T311 | The total adjusted approved amounts are required to be returned in the 835 at the service line and claim levels. | DHS | M | Any service lines that are not denied or suspended are input to the Reporting process that uses the DMH and ADP rate tables to determine the Total Approved Adjusted Amount. There is no mechanism to report at the HIPAA claim level. | SDOC |

[5] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[6] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory and O = Optional.

| New Requirements for HIPAA Compliance | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[5]** | **HIPAA Man. / Opt.[6]** | **GAP Description** | **Reference** |
| T313 | SD/MC needs to handle all incoming and outgoing data as well as the maintenance and accessibility of 6 years worth of adjudication and payment data. | ADP / DMH / DHS | M | EOB information in tables may be deleted, if space becomes tight but this is user directed. Not all of the EOB data is loaded to TAPS, ADP's data repository. | ABI, SDTI, ATI |
| T315 | HIPAA Compliance requires shared info to be in standard transactions, such as the 276 / 277 | ADP / DMH / DHS | M | The State has a stand-alone claim process and the Counties have limited ability to access the claim information stored there. | CNTY |
| T318 | Diagnosis must be submitted in the 837 | ADP | M | ADP reports getting a diagnosis for each client is an issue | ABI |
| T319 | DMH would like a more sophisticated system for Lockout. Time of day could help. | DMH | M | The 837I allows entry of Time of day for admissions and discharges, but SD/MC cannot use such data. | MBI |
| T320 | Need to be able to track units of service and date of service, which are HIPAA data elements. | DMH | M | SD/MC does not adjust units of service during adjudication. | MBI |
| T323 (F16) | The system must be able to recognize when payments are made outside of the adjudication process and must generate an 820 to match the payment | DMH | M | There is no specific mechanism for the system to recognize and register payments made outside of the claim adjudication process | MBI, HMAI |
| T324 (F4) | HIPAA Compliance requires that county generated claim & line ID be received, stored and reported; it would also help in the reconciliation process. | ADP / DMH / DHS | M | HIPAA line ID can be stored in current record layout, but claim ID cannot. | CNTY |
| T327 (A4) | HIPAA requires that an 835 be sent when payments are entirely offset | ADP / DMH / DHS | M | Nothing is sent out when payments are entirely offset. | CNTY |

| New Requirements for HIPAA Compliance | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[5]** | **HIPAA Man. / Opt.[6]** | **GAP Description** | **Reference** |
| T329 | HIPAA Compliant 835 must reports approved and denied claims | ADP / DMH / DHS | M | The proprietary EOB is currently relied upon to track approved and denied claims. | CNTY |
| T333 | The resubmittal must not restart the clock from the denied record. | ADP / DMH / DHS | M | Voids and resubmissions are covered under HIPAA and are required for HIPAA compliance. SD/MC does not support this process. | CNTY |
| T335 (D11) | Capture multiple diagnoses if reported on HIPAA transactions. | ADP / DMH / DHS | M | SD/MC can only handle one diagnosis code per service line | CNTY |
| T337 (D18) | Provider-to-payer COB is also needed. At least one county is set up to not bill Medi-Cal for clients with dual eligibility until the Medicare EOBs are received | ADP / DMH / DHS | M | Current Provider-to-payer COB is only partially handled through claim adjudication. | CNTY |
| T342 | Data elements required by the Implementation Guides (IGs), but not used by DMH, must be completed with a valid value to avoid compliance errors | DMH ADP | M | No gap in Phase I, but SD/MC is otherwise unable to validate all IG data elements. | MDOC |
| T344 | System must receive full-length elements. Can be truncated within the system but must be returned with full length data elements | DMH | M | Data elements with lengths greater than SD/MC definitions are truncated | MDOC |
| T346 | System must accept more than one SV2 segment and must figure out how to split the claim internally if it cannot process | DMH | M | Only one SV2 segment is accepted per CLM segment in Phase I. This is necessary to support a unique SD/MC Claim ID for each service line on an 837I | MDOC |

| New Requirements for HIPAA Compliance | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[5]** | **HIPAA Man. / Opt.[6]** | **GAP Description** | **Reference** |
| T347 | Must be sure that data coming back can be audited. All HIPAA data must be retrievable for internal use. | ADP | M | Current auditing capabilities are limited. | ABI |
| T353 (F2) | The system must be able to receive and process the required HIPAA transactions, e.g. 837 I, 837P, and 276 as well as three versions of each transaction, the previous version, the current version, and a future version in testing. | ADP / DMH / DHS | M | SD/MC cannot discern various types of transactions | RHIP |
| T354 (F3) | The system must determine which program is the responsible payer as well as unique characteristics of the payment method, e.g. DMH paying for EPSDT services differentiated from ADP paying for Drug Medi-Cal Services. | ADP / DMH / DHS | M | SD/MC can only determine the payer by manually labeling batches | RHIP |
| T3AA (D9) | Dates such as admission date are required when services are rendered in an inpatient setting. | ADP | M | Admit and discharge dates can be captured on ADP claims, but are not required. | ABI |
| T3AB | Updating of diagnostic & procedure codes must occur at HIPAA frequencies, at least quarterly. Run Logs are used by DHS/ITSD Data Guidance Unit to balance program inputs and outputs | ADP / DMH | M | User Maintenance consists of manual updates to tables and information used by the SD/MC system including: Federal Share Rates; Diagnostic Codes; Provider Master File; Cutoff Dates; HFP Hold Days; Rate Tables; Run Log | SDOC |

| New Requirements for HIPAA Compliance | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[5]** | **HIPAA Man. / Opt.[6]** | **GAP Description** | **Reference** |
| T3AD (C11) | System needs to execute in a manner that does not have an adverse impact on payment when processing HIPAA transactions versus other transactions. | DHS | N/A | SD/MC claim adjudication is executed four times a month with ADP / DMH input. This is not a gap, but a benchmark for future processing requirements. | SDTI |
| T3AE | SOC data should be used to adjust claims as appropriate. | ADP / DMH / DHS | M | HIPAA provides for reporting collected monies. SD/MC should recognize the amount collected on the claim and adjust the approved amount accordingly. | CNTY |
| T3AF | Establish a SCO interface to receive payment information, i.e. check amount and warrant number, required in compliant 835 transactions. | DHS | M | 'Information Only' 835 transactions are sent in response to electronic payment requests. | ADOC, MDOC |

**Table 5 – Current Requirements Not Covered by HIPAA**

| Current Requirements Not Covered by HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.**[7] | **HIPAA Man. / Opt.**[8] | **Issue or Comment** | **Reference** |
| T403 (C6) | SD/MC provider file at DHS requires synchronization with the County and DMH provider files. The process: 1) Counties receive a Provider ID from DMH; 2a) Counties certify contract providers, maintain county provider file and send certification to DMH; 2b) DMH certifies county run providers; 3) DMH activates in DMH provider file and notifies DHS and EDS; 4) DHS activates in the SD/MC 5) EDS adds to Medi-Cal provider file and sends an authorization letter allowing access to automated eligibility file | DMH | N/A | The provider file may be impacted depending on the solution alternative selected. | MBI |
| T405 | Adjudicated claim data is downloaded to a server for reporting | DMH | N/A | The data available for download will change. | MBI |
| T406 | Approved Services Report is the SD/MC report used by DMH. | DMH | N/A | | MBI |
| T407 | The system needs to send paid claims data to the MIS/DSS | ADP DHS DMH | N/A | S035 formatted file is necessary for the MIS/DSS system at DHS. | MBI |
| T415 | ADP & DMH invoices to DHS show Dollars billed with State Funds, Dollars billed for FFP, the FFP% and the total of both dollar columns. Invoice detail reflects the same columns for each county plus month of service and month payment is due | ADP / DMH | N/A | Invoices between the departments are not covered by HIPAA. | HAAI, HMAI |

[7] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.
[8] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory, O = Optional, and N/A = Not Applicable.

| Current Requirements Not Covered by HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[7]** | **HIPAA Man. / Opt.[8]** | **Issue or Comment** | **Reference** |
| T416 | ADP & DMH invoices to DHS are checked to ensure that the new expenditures combined with the accumulated total does not exceed contract amounts. When the amount is exceeded, an amendment may be requested. In this case the invoice is placed on hold until the funds are approved for payment. Nearly 50% of the DMH invoices are revised. | DHS | N/A | Invoices between the departments are not covered by HIPAA. | HAAI, HMAI |
| T418 (C5) | DHS Accounting uses the CMS64 system to interface with CAL-STARS, to request matching federal funds | DHS | N/A | | HMAI |
| T423 | The Batch Reconciliation process verifies the total dollar amount and number of claims on electronic and paper claims submitted by the counties. Inconsistencies are corrected prior to submitting the claims to the Data Edits process. User controls and payment release are tied to the batching process. | ADP / DMH | N/A | | SDOC |
| T424 | At the completion of processing, DHS notifies ADP / DMH with an e-mail containing Data Set Names (DSN) of the output report / files | DHS | N/A | | SDTI |
| T425 | Charges are accumulated and charged to MSD1001 for the computer processing | DHS | N/A | | SDTI |
| T427 | The Eligibility process must verify Medi-Cal and Healthy Families eligibility for recipients of the Short Doyle / Medi-Cal services | DHS | N/A | | SDOC |

| Current Requirements Not Covered by HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[7]** | **HIPAA Man. / Opt.[8]** | **Issue or Comment** | **Reference** |
| T428 | A claim is denied if a non-Federal Financial Participation (FFP) Aid Code was returned from MEDS | DHS | N/A | | SDOC |
| T429 | FFP Rate tables are used to determine FFP rates and calculate the FFP Approved Amount for each approved claim | DHS | N/A | | SDOC |
| T432 (C5) | The Claim Payment Request process at DMH consists of preparation of the Claim Schedule for the State Controller's Office (SCO) by DMH Accounting staff from the Expenditures Reports | DMH | N/A | SCO results do not interface with SD/MC history (required for 835 generation) | SDOC |
| T433 | The SD/MC Invoice to DHS is prepared by DMH using the SD/MC Claim Schedule information. | DMH | N/A | | SDOC |
| T437 | Copies of the invoice are produced and forwarded to DHS Accounting | DHS | N/A | | HMAI |
| T440 | Most submitters include all of their claims in one transaction. A consistent exception is LA County, who usually submits five transactions. | ADP | N/A | | ATI |
| T441 (C5) | From data loaded into TAPS and reports based on these data, the ADP Accounting Office (FASB) generates a paper Remittance Advice and schedules the warrant generation in CalStars. The State Controller's Office (SCO) combines the paper Remittance Advice with the warrant and mails them to the counties or direct providers. | ADP | N/A | There is no return interface from the SCO with results of the process | ADOC |

| Current Requirements Not Covered by HIPAA | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Requirement Description** | **Req. Org.[7]** | **HIPAA Man. / Opt.[8]** | **Issue or Comment** | **Reference** |
| T4AA (B8) | A different set of codes is used for Federal reporting than those used in Short Doyle | DMH | N/A | SD/MC currently uses proprietary codes. Ideally, federal reporting should use HIPAA standard code sets. | MBI |
| T4AB | Entire claim is denied when SOC is not met. (Example: If a claim is submitted for $5,000 with SOC of $300, entire claim is denied because SOC was not met) | ADP / DMH / DHS | N/A | Providers will continue to need to clear SOC through the eligibility transactions. | CNTY |
| T4AD | ADP and DMH will receive paper transactions from counties under certain circumstances. | ADP / DMH | O | HIPAA TCS does not cover paper processes. | ABI, MBI |
| T4AE | Counties also submit research data which falls within the HIPAA security and privacy regulations but not the data regulations | ADP | N/A | If the data comes in on the transaction, it should not be asked for in another format. | ATI |

**Table 6 – Technical Process Improvement Opportunities**

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T501 (D10) | ADP would like to see claims with patterns of abuse or overuse, stopped with a pre-payment edit, instead of after the fact with the resulting need to recover the money. Example: a client may be enrolled in three different programs, all of which are billed for consultation | ADP | N/A | SD/MC is not programmed to facilitate monitoring of claiming patterns. HIPAA provides the information that allows the edit at adjudication | ABI |
| T502 | ADP wants all reports sent electronically to the department | ADP | N/A | Many SD/MC reports are on the mainframe or printed to paper. | ABI |
| T503 | Need audit criteria that monitors for fraud (excessive billing) on a post payment basis | ADP | N/A | SD/MC does not process information beyond the adjudication process. HIPAA requires that 6 years of adjudicated data be retained and available for various purposes, including fraud detection | ABI |
| T504 | Queries should be flexible and composed at the time of the query, and able to access all data that is in the system but not reported in canned reports, Real-Time - avoiding downloads. | ADP / DMH | N/A | SD/MC does not support ad hoc queries by the departments. HIPAA requires that 6 years of adjudicated data be retained and available for various purposes | ABI, MBI |
| T508 | Would like to see reporting of what we are paying & to whom we are paying - by Provider ID or county code with a breakdown of each payment | ADP | N/A | The reporting described does not exist in SD/MC. | ABI |

[9] This is an indicator of the organization that either specifically requested a requirement or that the requirement was developed through documentation or meetings with the organization listed.

[10] This is the determination of whether the requirement must be met to ensue HIPAA compliance. M = Mandatory, O = Optional, and N/A = Not Applicable.

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T509 | Management reports that periodically report on a contract level, Appropriated vs. Paid | ADP / DMH | N/A | The reporting described does not exist in SD/MC. | ABI, MBI |
| T511 | Monthly, quarterly or periodic reports that report billed and paid | ADP / DMH | N/A | The reporting described does not exist in SD/MC. | ABI, MBI |
| T512 | Need the functionality of the current EOB, I.e. merging of the info in the 837, 835 & MEDS | DMH | N/A | As long the intended usage is internal, there is no compliance issue. | MBI |
| T513 | When eligibility is forced, the system should capture why & who performed the override to the claim | DMH | N/A | HIPAA allows for emergency codes for override and for late filing indicators. | MBI |
| T515 | DMH would like to be able to guarantee eligibility, once a provider has been told a client is eligible, even though a subsequent update removed the eligibility. Like the current Medi-Cal process run by EDS | DMH | N/A | SD/MC has no access to the Eligibility Verification Control Log. SD/MC should access Medi-Cal eligibility inquiry records to verify Medi-Cal status at the time of inquiry to accurately process claims | MBI |
| T516 | Improve overall processing time to enable quicker payments. | DMH | N/A | The payment processes between DMH, DHS, and SCO are largely manual. | MBI |
| T520 (E25) | Counties would like EFT | DMH | N/A | Counties currently receive paper checks. | MBI |
| T521 | Need to share client info between counties. Client's are in another county but original county doesn't know that fact until a claim is denied as a duplicate service | ADP / DMH / DHS | N/A | SD/MC should make better use of the 835. In this case, an identifiable ARC and/or Remarks code to indicate this scenario occurred could be placed on the 835. | CNTY |

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T528 | Need to be able to reconcile Cost Data before Auditors arrive. Cost report data should be available more often than annually. Auditors look at Approved data only, they do not look at the total picture. | ADP / DMH / DHS | N/A | The capability described does not exist in SD/MC. | CNTY |
| T529 (C13) | Must be able to reconcile all previous codes after HIPAA | ADP / DMH / DHS | N/A | There will be an overlap of compliant and non-compliant codes that will impact data analysis. | CNTY |
| T530 | Counties would like improvement in the 7-10 day claim turn around (Would like a process similar to Medicare's, where within 48 hours of submission they can pull up a screen that shows received, approved, denied and date when payment will be made) | ADP / DMH / DHS | N/A | The current collection of processes appears to take a significant amount of time to generate actual payment. | CNTY |
| T531 (D17) | Utilize Secure FTP to receive and transmit HIPAA transactions. | ADP / DMH / DHS | N/A | Current processes require manual interaction. HIPAA security regulations will require a secure transfer mechanism. Secure FTP is only one way to achieve this. | CNTY |
| T532 | Would like an exception report of claim submission patterns to assist in detecting a recurring problem (example: Medicare reports counts of denials by code) | ADP / DMH / DHS | N/A | The report described does not exist in SD/MC. | CNTY |
| T539 (E11) | Digitized Signatures must be agreeable to counties, as well as the State | ADP / DMH / DHS | N/A | No digital signature standard has been identified, nor has there been agreement to use them. | CNTY |

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T542 (E17) | Link services to specific diagnoses | ADP | O | The capability described does not exist in SD/MC. | ABI |
| T602 (B11) | DHS needs to retain more info from MEDS and make it available, such as Language, Date Of Birth, Admit Date, Gender, Other Insurance, Medicare A & B, etc | DMH | N/A | All of these data elements except Language must come in on the transaction if they exist, such as admit date. DHS cannot make the language info from MEDS available on any transaction. It is not a code set on anything but the 834. MEDS data for internal use is not covered. | MBI |
| T6AA (E28) | Would like summaries that show how much was paid for FFP and how much is yet to come. Want to look at all of the data the State has, what is paid and what is owed | ADP / DMH / DHS | N/A | Summary data reports are not covered by HIPAA as long as they do not replace | CNTY |
| T6AB | ADP & DMH should change CADDS, CSI, and other systems reporting service data to accept the HIPAA code sets. | ADP / DMH / DHS | O | The Collaborative HIPAA Implementation Project (CHIP) agreed that CSI and CADDS are not covered under HIPAA. Requiring the same data to be reported with different code sets diminishes the intent of Administrative Simplification. | CNTY |
| T6AC (E10) | When in an Institution for Mental Disease (IMD), would like to be able to edit against services rendered by someone else | DMH | O | May require complex criteria. | MBI |
| T6AD (D12) | The system should allow overrides to SD eligibility for specific circumstances that are within State and Federal regulations. | ADP | O | Business process Improvement under HIPAA | ABI |

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T6AE | SD/MC should support the ability for DHS (or its agent) to receive, process and pay all claims directly, if and when it is decided to adjudicate in this manner. (Providers submit directly to DHS and have payment sent directly back to the providers) | ADP DMH | O | Current process has DHS adjudicate claims, then send data back to ADP and DMH to determine payment amounts and trigger payment to counties from SCO. | ABI |
| T6AF (C2) | Counties want the Aid Code that was used to approve a service, reported back for several purposes under the headings of financial and analytical reasons. A key purpose is confirming Healthy Families clients versus regular SD/MC. The Aid Code is also useful for Cost Reporting, tracking EPSDT services, identifying services that may be 100% State Funds or 100% Federal Funds. | ADP / DMH / DHS | N/A | May need to use a mixture of data fields to determine the Aid code. | CNTY |
| T6AG | Counties will eventually be required to submit claims in an electronic, HIPAA compliant format. | ADP | O | Counties and direct providers currently submit HIPAA compliant, proprietary electronic, and paper transactions. | ABI |
| T6AH (E36) | Medicare payer-to-payer Coordination of Benefits (COB) is desired. | ADP / DMH / DHS | O | SD/MC cannot handle COB. HIPAA enables payer to payer COB. SD/MC must recognize the CPT code equivalent of the HCPCS codes | CNTY |

| Technical Process Improvement Opportunities | | | | | |
|---|---|---|---|---|---|
| **Unique ID** | **Technical Improvement Opportunity Description** | **Req. Org.[9]** | **HIPAA Man. / Opt.[10]** | **Comments or Issues** | **Reference** |
| T6AJ | Use the HIPAA override capability for defined situations. (Example: Once a claim is paid for a given client / service / date, legitimate claims for the same service will not pay and there is no automated override process available.) | DHS | N/A | Claims deny for legitimate services | SDTI |
| T6AK | Accounting would like to see a more level flow of invoicing. Frequency varies. They may be received weekly, bi-weekly and monthly. It is not unusual to receive 10 or 12 at a time, especially at month end. Timing of the receipt of DMH invoices for matching FFP often creates problems, especially at year-end. Amendments are often requested late with a 6/30 expected date, causing a labor-intensive fast track process. It can take 16 months to receive a requested report | DHS | N/A | | HMAI |
| T6AM (C14) | Some error detection is performed as claims are received. When appropriate, the counties would like to see the field ID that is associated with the error. | ADP / DMH / DHS | O | The 997 can specify the data element(s) that trigger a rejection. | CNTY |

## 2.2 DHS SD / MC Processes Requiring Change

This section describes the differences between the existing DHS processes within SD/MC compared to HIPAA requirements. Process steps may contain more features than are listed, but only the features requiring change due to HIPAA requirements are described. The table represents where the affected process occurs; however, it is not mandated that the change will occur in the listed process. Designers may propose a different approach. The Req. Reference Column identifies the requirement that drives the change and lists the Unique ID from the overall requirements list found in Section 2.1.

**Table 7 – DHS Processes within SD/MC**

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| Apply Corrections | | | | | |
| | HDMS400 | | Applies corrections to Suspense Master | Discontinue process | T301 |
| | HDMS400 | SORT | Sorts corrections | Discontinue process | T301 |
| | HDMS400 | MSD140 | Matches Suspense Master | Discontinue process. If Suspense master continues, convert to 837 format and change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T301, T209 |
| Batch Reconciliation | | | Prepares data received from ADP & DMH for editing | | |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD402 | | Executes sort | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD402 | SORT | Combines ADP & DMH data and separates in-balance batches from out-of balance | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| Data Edits | | | | | |
| | HDMSD404 | | Executes MSD110 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD404 | MSD110 | Checks field values, valid claim ID, provider is eligible, valid receipt date, aid code, sex, diagnosis, race / ethnicity, service function code and checks for duplicate claim ID in the current stream and in suspense. Posts error messages to the claim if in error. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Use HIPAA compliant data fields and values. See individual requirements for fields and field values. Change to use compliant error messages and codes. Claims should approve or deny with suspends limited to circumstances not under the submitters control, i.e. support files with erroneous data. Program code is not a HIPAA element, system should determine the program and payer. The system must receive claim and line IDs. The system must recognize and handle voids & resubmissions. Processing Direct Providers and counties alike may not be compliant. | T209, T221, T1AA, T6AF, T229, T230, T231, T222, T236, T117, T114, T227, T4AA, T219, T303, T320, T318, T335, T346, T342. T324, T301, T333, T6AJ, T501, T542, T223, T344, T354 |
| Client Eligibility | | | | | |
| | HDMSD415 | | Executes SORT & MSD125 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD415 | SORT | Sorts claims for eligibility match | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD415 | MSD125 | Matches to eligibility files (MEDS & Xref files). Pulls data from MEDS and posts to claim. Suspends claims if MEDS indicates Medicare or Other Coverage. Posts error messages to the claim if in error. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Most of the data pulled from MEDS must be received within the 837, it may no longer be captured from MEDS. Claims are to be denied when claim indicates other payer is available. Change to use compliant error messages and codes. Request capture of override info from 837. | T209, T221, T429, T602, T2AA, T231, T222, T204, T515, T427, T513 |
| | HDMSD420 | | Executes SORT & MSD120 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD420 | SORT | Sorts claims for eligibility match with service date older than 16 months | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD420 | MSD120 | Matches to files with eligibility older than 16 months (MMEF & HIS Database file). Pulls data from MMEF and posts to claim. Suspends claims if MMEF indicates Medicare or Other Coverage. Posts error messages to the claim if in error. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Most of the data pulled from MMEF must be received within the 837. Claims are to be denied when claim indicates other payer is available. Change to use compliant error messages and codes. Request capture of override info from 837. | T209, T221, T429, T602, T2AA, T231, T204, T427, T513 |
| Pricing and Error Reporting | | | | | |
| | HDMSD430 | | Executes SORT and MSD130 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD430 | SORT | Combines claims with eligibility older than 16 months with more current eligibility. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD430 | MSD130 | Creates the Error Correction Report (ECR). Claims without critical errors have an approved amount calculated and posted. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Information in ECR must be returned in HIPAA compliant transaction for claims submitted in the 837, such as in an Unsolicited 277. . The system must recognize claim & line IDs. The system must recognize and handle voids & resubmissions. | T209, T225, T119, T311, T201, T324, T301, T333, T6AJ, T3AE, T4AB, T429 |
| | HDMSD432 | | Executes MSD176 (only process affected by HIPAA within the job) | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD432 | MSD176 | Matches claims to MEDS Xref to find MEDS ID | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD441 & HDMSD442 | | Executes SORT & MSD170 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD441 & HDMSD442 | SORT | Sorts claims for match to the Duplicate Check Master | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD441 & HDMSD442 | MSD170 | Checks for duplicates against history. | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Change dup logic to recognize HIPAA fields (includes dates, procedure codes, etc.). Dups should be denied with an expanded message in the 835. | T209, T236, T3AA, T521 |
| Reporting | | | | | |
| | HDMSD450 | | Executes SORT & MSD150 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD450 | SORT | Combines approved & rejected files for reporting | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD450 | MSD150 | Produces Summary reports to counties (& end of year) | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Change Service code reporting to HIPAA codes. | T209. T229, T230 |
| | HDMSD453 | | Executes SORT & MSD153 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD453 | SORT | Splits into approved & denied files for ADP reporting to the counties | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837p | T209 |
| | HDMSD453 | MSD153 | Produces Summary reports to counties (& end of year) | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837p. Change Service code reporting to HIPAA codes. | T209, T229 |
| | HDMSD455 & HDMSD457 | | 455 consists of sorts and MSD155 Execution with ADP data and 457 does the same for DMH data | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD455 & HDMSD457 | SORT | Splits into DMH & ADP for reporting to the counties | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD455 & HDMSD457 | MSD155 | Produces Summary reports to counties (& end of year) | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837p & 837i. Change Service code reporting to HIPAA codes. | T209, T229, T230 |
| | HDMSD458 | | Executes sort & MSD157 | | |
| | HDMSD458 | SORT | Sorts for MSD157 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD458 | MSD157 | Reads Approved Claims and generates four reports | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837p & 837i. Change Service code reporting to HIPAA codes. Reports requested as electronic instead of hardcopy | T209, T229, T230, T502 |
| | HDMSD460 | | Executes two SORT steps | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD460 | SORT | Sorts Approved files into a single file | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD460 | SORT | Sorts Suspense files into single file | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD465 | | Executes three SORT steps | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD465 | SORT | Sorts five denied, suspense and reject files into a single aged denied file | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD465 | SORT | Sorts aged denied file into DMH denied file and four ADP denied / aged files | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD468 | | Executes MSD160 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD468 | MSD160 | Reads Denied and Suspense files created in HDMS468 and generates 7 reports of suspense and denied claims for DMH & ADP | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Reports requested as electronic instead of hardcopy | T209, T502 |
| | HDMSD470 | | Executes one sort and three reporting programs | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD470 | SORT | Sorts denied claim file together for MSD142 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD470 | MSD131 | Reads Claims file and generates four summary reports of approved claims | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Reports requested as electronic instead of hardcopy | T209, T502 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD470 | MSD132 | Reads Claims file and generates four summary reports of suspended claims | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Reports requested as electronic instead of hardcopy | T209, T502 |
| | HDMSD470 | MSD142 | Reads Denied/Aged Claims file and generates four summary reports of denied and aged claims | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Reports requested as electronic instead of hardcopy | T209, T502 |
| | HDMSD490 | | Executes eight sorts | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD490 | SORT (8) | Sorts create Suspense master and files for the library | All eight sorts read and write proprietary 350 byte records which must change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | HDMSD491 | | Executes sort to create EOB files | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |

| DHS Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | HDMSD491 | SORT | Reads Approved, Denied & Suspense files creating separate EOB files for ADP & DMH | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p. Compliant 835 is to be returned with payment information, instead of the EOB. Change paper EOBs so they resemble 835s. Suspense records should not be on the 835. | T209, T208, T210, T214, T215 |

## 2.3 ADP SD / MC Related Processes Requiring Change

This section describes the differences between the existing ADP processes within the SD/MC process compared to HIPAA requirements. Processes not affected by HIPAA are excluded. Only the processes requiring change are described. The table represents where the affected process occurs; however, it is not mandated that the change will occur in the listed process. Designers may propose a different approach that removes the need for the process. The Req. Reference Column identifies the requirement that drives the change and lists the Unique ID from the overall requirements list found in Section 2.1.

**Table 8 – ADP Mainframe Processes within SD/MC**

| ADP Mainframe Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| Batch Reconciliation | | | Compares computed claim amounts and counts to batch total records (process is redundant to TAPS processes) | | |
| | OAMSD106 | | ADP run Job, (uses ADP data), executes program MSD106 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | OAMSD106 | MSD106 | Performs balance of amounts and counts and formats 157 byte proprietary record to 350 byte SD/MC format | Change input and output record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p (entire process is redundant & could be eliminated) | T209 |

**Table 9 – ADP Server Processes within SD/MC**

| ADP Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts** | **Function / Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| AOD Infonet (Upload Handler) | | | | | |
| | httpost.asp | | Receive files from ITWS | ADP must receive HIPAA transaction 837p | T209 |
| | | Main Script | Interrogates data & invokes pre-edits | Pre-edits should be applied to the 837p. Program code must be recognized as another element | T209, T219, T1AA, T353 |
| AOD Infonet (DMC / CADDS Invoker) | | | Stores claims and performs pre-edit | Pre-edits should be applied to the 837p. Program code must be recognized as another element. | T209, T219. T1AA |
| | files.asp | | Write the data files to the local disk and call the pre-edits programs | Pre-edits should be applied to the 837p. Data should be stored in the 837p format. Program code must be recognized as another element | T209, T219 |
| | | WriteDataFile | Store Incoming data | Data should be stored in the 837p format | T209 |
| | | StartDMCProcess | Call Pre-edit program | Pre-edits should be applied to the 837p. Program code must be recognized as another element | T209, T219 |
| TAPS | | | ADP Data Repository | Data should be stored in the 837p format, the system should recognize the incoming 276 and create the 277. Need to store 6 years of all history with payment storing all data in the | T209, T1AA, T353, T313, T3AF, T441. |

| ADP Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts** | **Function / Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | | | | 835. SCO should return payment info for 835 generation. | |
| | SqlLdr_eob.bat - | | Load EOB into Oracle | Need to store 6 years of all history. Payment history should store all 835 elements, SCO should return payment info for 835 generation | T313, T214, T224, T3AF, T441 |
| | | EXPLAIN_OF_BALANCE | Oracle EOB table | Need to store 6 years of all history. Payment history should store all 835 elements and should be able to reconcile all previous codes to HIPAA codes in history. SCO should return payment info for 835 generation | T313, T214, T529, T3AF, T441 |
| | | DMC_Billing | Oracle table | Data should be stored in the 837p format & made available. Should be able to reconcile all previous codes to HIPAA codes in history | T209, T504, T529 |
| | | DMC_Approved_Service | Oracle table | Data should be stored in the 835 format & made available. Should be able to reconcile all previous codes to HIPAA codes in history | T512, T504, T529 |

| ADP Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts** | **Function / Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | | DMC_Claim_Suspend | Oracle table | Claims should only be suspended for circumstances not within submitter control, i.e. errors in support file | T117 |
| | | Explain_Of_Balance | Oracle table | Data should be stored in the 835 format. Should be able to reconcile all previous codes to HIPAA codes in history | T512, T529 |
| Translator | | | Translates 837 format claims to proprietary format and translates EOBs to non-compliant 835s. Also applies HIPPA edits to incoming transactions. | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | ew_ADP_837P_To_SDMC_LARGE | | Translates 837p to proprietary | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | et_adp_sdmc_claim_file | Proprietary Claims | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | ADP_HIPAA_PT_DATA | Pass thru database | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | ew_sdmc_eob_append | | Adds data to EOB from pass thru db | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |

| ADP Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts** | **Function / Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | | et_adp_sdmc_eob | EOB File sent to translator | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | ew_ADP_SDMC_EOB_Sort | | Sorts EOB records to allow claim lines to be grouped within remittances | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | ew_ADP_SDMC_EOB_To_835_Custom | | Translates EOB to 835 | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | adp_iqmgr_JMS | | Translates EOB to 835 | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |

## 2.4 DMH SD / MC Processes Requiring Change

This section describes the differences between the existing DMH processes within SD/MC compared to HIPAA requirements. Processes not affected by HIPAA are excluded. Only the processes requiring change are described. The table represents where the affected process occurs, however it is not mandated that the change will occur in the listed process. Designers may propose a different approach. The Req. Reference Column identifies the requirement that drives the change and lists the Unique ID from the overall requirements list found in Section 2.1.

**Table 10 – DMH Mainframe Processes within SD/MC**

| DMH Mainframe Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Job Control Language (JCL)** | **Programs** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| Batch Reconciliation | | | Compares computed claim amounts and counts to batch total records (process is redundant to ITWS processes) | | |
| | MHMSD106 | | DMH run Job, (uses DMH data), executes program MSD106 | Change record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p | T209 |
| | | MSD106 | Performs balance of amounts and counts and formats 157 byte proprietary record to 350 byte SD/MC format | Change input and output record lengths, block sizes and file types to be compatible with HIPAA transactions 837i & 837p (entire process is redundant & could be eliminated) | T209 |

**Table 11 – DMH Server Processes within SD/MC**

| DMH Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts / Procedures** | **Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| ITWS | | | Receives and sends electronic claims data to and from counties and direct providers. | | |
| | spAFTNofify | | Triggers the 837 → PRO process by inserting a record in translator table | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | spAFTSDMC 835Notify | | Notifies the status & result of EOB → 835 translator process to DSS | To be in HIPAA Compliance, a compliant 835 must be returned. | T306, T224 |
| | spAFTSDMC ClaimUpdate | | Validates the incoming 837/997/PRO files and accepts/rejects based on business rules | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | spReportSD MCSystemEr rors | | Monitors and reports any translator system errors. (Reports if no 997/PRO is received from translator within 5 hours of a claim submission) | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | spAFTSDMC ECFUpdate | | Validates the incoming ECF files and accepts/rejects based on business rules | To be compliant, the system must handle voids and resubmissions with revised data content. The current correction process is not HIPAA compliant. | T301 |

| DMH Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts / Procedures** | **Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | spCreateDHSECFFile | | Creates the weekly ECF file to send it to DHS | To be compliant, the system must handle voids and resubmissions with revised data content. The current correction process is not HIPAA compliant. | T301 |
| | Sdmcecfs.asp | | Interface for validating ECFs | To be compliant, the system must handle voids and resubmissions with revised data content. The current correction process is not HIPAA compliant. | T301 |
| | | SDMCECFRecords | Stores data in a ECF file temporarily | To be compliant, the system must handle voids and resubmissions with revised data content. The current correction process is not HIPAA compliant. | T301 |
| | | DHSECFS | Logs information about the weekly ECF files sent to DHS | To be compliant, the system must handle voids and resubmissions with revised data content. The current correction process is not HIPAA compliant. | T301 |

| DMH Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts / Procedures** | **Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| Translator | | | Translates 837 format claims to proprietary format and translates EOBs to non-compliant 835s. Also applies HIPPA edits to incoming transactions. | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | ew_DMH_837P_To_SDMC_LARGE | | Translates 837p to proprietary | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | et_dmh_sdmc_claim_file | Proprietary Claims | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | DMH_HIPAA_PT_DATA | Pass thru database | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | ew_DMH_837I_To_SDMC_LARGE | | Translates 837i to proprietary | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | et_dmh_sdmc_claim_file | Proprietary Claims | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | | DMH_HIPAA_PT_DATA | Pass thru database | To be in HIPAA Compliance, proprietary claims must be discontinued. | T209, T306 |
| | ew_sdmc_eob_append | | Adds data to EOB from pass thru db | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |

| DMH Server Processes within SD / MC | | | | | |
|---|---|---|---|---|---|
| **Application** | **Scripts / Procedures** | **Tables** | **Description** | **Required Change to be HIPAA Compliant** | **Req. Reference** |
| | | et_dmh_sdmc_eob | EOB File sent to translator | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | ew_DMH_SDMC_EOB_Sort | | Sorts EOB records to allow claim lines to be grouped within remittances | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | ew_DMH_SDMC_EOB_To_835_Custom | | Translates EOB to 835 | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |
| | dmh_iqmgr_JMS | | Translates EOB to 835 | Compliant 835s must be generated based on the 837 and payment info. | T208, T210 |

## 2.5 Additional Requirements not within Existing Processes

There are several additional requirements for SD/MC to be HIPAA compliant. For the most part, these are processes that are outside the existing system or they are of a general nature that affects the overall system but not a particular existing Job or Script. These requirements follow.

**Table 12 – Mandated Additional Requirements – SD/MC**

| Mandated Additional Requirements - SD/MC | | |
|---|---|---|
| **Requirement Description** | **GAP Description** | **Req. Reference** |
| The system needs to implement the 276/277 as an electronic method of claim status request / response that is HIPAA compliant. | Some non-compliant electronic claim status is available. No electronic request / response process exists. | T213 (B9, D8) |
| The 835 Implementation Guide notes that in the case of a paper check, the check number should be used as the Reassociation Trace Number. The documentation provided with the actual check will need to provide all of the SD/MC Batch Numbers that are being paid from that check. The 835 carries all the information regarding claims associated with the check payment. If the 835 carries the check number then the check number doesn't have to carry the batch or claim information. | Neither the EOB nor Phase I 835 include the check number. | T217 (E25) |
| The system must capture and store links to locate a claim in order to report the status. The 276 Transaction allows the requestor to request information at the claim level or the service line level. It allows a requestor, who does not know the claim number, to provide related information (e.g., beneficiary ID, Date of Service, Procedure Code) so that the payer can find the claim that meets the search criteria and provide status via the 277 | The system has no specific processes in place to locate a claim and report status. | T218 (D4) |
| Counties will eventually be required to submit claims in an electronic, HIPAA compliant format. | Counties and direct providers currently submit HIPAA compliant, proprietary electronic, and paper transactions. | T6AG |
| The system needs to manage the maximum number of claims with out a run time impact. System needs to be sized so that projected volumes have no impact. | 200,000 to 600,000 DMH claims are processed per cutoff period. This is not a gap, but is a benchmark for processing requirements. | T309 |

| Mandated Additional Requirements - SD/MC | | |
|---|---|---|
| **Requirement Description** | **GAP Description** | **Req. Reference** |
| HIPAA Compliance requires shared info to be in standard transactions, such as the 276 / 277 | The State has a stand-alone claim process and the Counties have limited ability to access the claim information stored there. | T315 (E27) |
| HIPAA requires that an 835 be sent when payments are entirely offset | Nothing is sent out when payments are entirely offset | T327 (A4) |
| HIPAA Compliant 835 reports Paid and Denied claims | The proprietary EOB is currently relied upon to track paid and denied claims. | T329 |
| Must be sure that data coming back can be audited. All HIPAA data must be retrievable for internal use. | Current auditing capabilities are limited. | T347 |
| System needs to execute in a manner that does not have an adverse impact on payment when processing HIPAA transactions versus other transactions. | SD/MC claim adjudication is executed four times a month with ADP / DMH input. This is not a gap, but a benchmark for future processing requirements. | T3AD (C11) |
| Updating of diagnostic & procedure codes must occur at HIPAA frequencies, at least quarterly. Run Logs are used by DHS/ITSD Data Guidance Unit to balance program inputs and outputs | User Maintenance consists of automated and manual updates to tables and information used by the SD/MC system including: Federal Share Rates; Diagnostic Codes; Provider Master File; Cutoff Dates; HFP Hold Days; Rate Tables; Run Log | T3AB |
| Need audit criteria that monitors for fraud (excessive billing) on a post payment basis | SD/MC does not process information beyond the adjudication process. HIPAA requires that 6 years of adjudicated data be retained and available for various purposes, including fraud detection | T503 |
| Counties also submit research data which falls within the HIPAA security and privacy regulations but not the data regulations | If the data comes in on the transaction, it should not be asked for in another format because the SDMC rejected it initially | T4AE |
| Establish a SCO interface to receive payment information, i.e. check amount and warrant number, required in compliant 835 transactions | 'Information Only' 835 transactions are sent in response to electronic payment requests. | T3AF |

In addition to the HIPAA Mandated Additional Requirements there are several optional requirements. Many are made possible by the HIPAA regulations, but some are requests that were made in order to achieve business improvements. The optional requirements follow.

**Table 13 – Optional Additional Requirements – SD/MC**

| Optional Additional Requirements - SD/MC | | |
|---|---|---|
| **Requirement Description** | **Comment** | **Req. Reference** |
| ADP and DMH must state whether or not they will receive paper from counties. | HIPAA TCS does not cover paper processes, but it is an important requirement for solution alternatives. | T4AD |
| When in an IMD, would like to be able to edit against services rendered by someone else | May require complex criteria. | T6AC (E10) |
| The system should allow overrides to SD eligibility for specific circumstances that are within State and Federal regulations. | Business process Improvement under HIPAA | T6AD (D12) |
| DMH would like a more sophisticated system for Lockout. Time of day could help | The 837I allows entry of Time of day for admissions and discharges, but SD/MC cannot use such data. | T319 |
| The system must be able to recognize when payments are made outside of the adjudication process and must generate an 820 to match the payment | There is no specific mechanism for the system to recognize and register payments made outside of the claim adjudication process | T323 (F16) |
| Would like summaries that show how much was paid for FFP and how much is yet to come. Want to look at all of the data the State has, what is paid and what is owed | | T6AA (E28) |
| Medicare payer-to-payer Coordination of Benefits (COB) is desired. | SD/MC cannot handle COB. HIPAA enables payer to payer COB. SD/MC must recognize the CPT code equivalent of the HCPCS codes | T6AH (E36) |
| Provider-to-payer COB is also needed. At least one county is set up to not bill Medi-Cal for clients with dual eligibility until the Medicare EOBs are received | Current Provider-to-payer COB is only partially handled through claim adjudication. | T337 (D18) |
| Approved Services Report is the SD/MC report used by DMH. | | T406 |
| ADP & DMH invoices to DHS show Dollars billed with State Funds, Dollars billed for FFP, the FFP% and the total of both dollar columns. Invoice detail reflects the same columns for each county plus month of service and month payment is due | | T415 |

| Optional Additional Requirements - SD/MC | | |
|---|---|---|
| **Requirement Description** | **Comment** | **Req. Reference** |
| ADP & DMH invoices to DHS are checked to ensure that the new expenditures combined with the accumulated total does not exceed State General Funding. When the amount is exceeded, an amendment maybe requested. In this case the invoice is placed on hold until the funds are approved for payment. Nearly 50% of the DMH invoices are revised | | T416 |
| DHS Accounting uses the CMS64 system to interface with CAL-STARS, to request matching federal funds | | T418 (C5) |
| Charges are accumulated and charged to MSD1001 for the computer processing | | T425 |
| The Claim Payment Request process at DMH consists of preparation of the Claim Schedule for the State Controller's Office (SCO) by DMH Accounting staff from the Expenditures Reports | SCO results do not interface with SD/MC history (required for 835 generation) | T432 (C5) |
| The SD/MC Invoice is prepared by DMH using the SD/MC Claim Schedule information. | | T433 |
| Copies of the invoice are produced and forwarded to DHS Accounting | | T437 |
| Accounting would like to see a more level flow of invoicing. Frequency varies. They may be received weekly, bi-weekly and monthly. It is not unusual to receive 10 or 12 at a time, especially at month end. Timing of the receipt of DMH invoices for matching FFP often creates problems, especially at year-end. Amendments are often requested late with a 6/30 expected date, causing a labor-intensive fast track process. It can take 16 months to receive a requested report | | T6AK |
| Would like to see reporting of what we are paying & to whom we are paying - by Provider ID or county code with a breakdown of each payment | | T508 |
| Management reports that periodically reports on a contract level, Appropriated vs. Paid | | T509 |

| Optional Additional Requirements - SD/MC | | |
|---|---|---|
| **Requirement Description** | **Comment** | **Req. Reference** |
| Monthly, quarterly or periodic reports that report allocated, billed and paid | | T511 |
| Improve overall processing time to enable quicker payments. | The payment processes between DMH, DHS, and SCO are largely manual. | T516 |
| Counties would like EFT | | T520 (E25) |
| Need to be able to reconcile Cost Data before Auditors arrive. Cost report data should be available more often than annually. Auditors look at Approved data only, they do not look at the total picture. | | T528 |
| Counties would like improvement in the 7-10 day claim turn around (Would like a process similar to Medicare's, where within 48 hours of submission they can pull up a screen that shows received, approved, denied and date when payment will be made) | The current collection of processes appears to take a significant amount of time to generate actual payment. | T530 |
| Would like an exception report of claim submission patterns to assist in detecting a recurring problem (example: Medicare reports counts of denials by code) | | T532 |
| Digitized Signatures must be agreeable to counties, as well as the State | No digital signature standard has been identified, nor has there been agreement to use them. | T539 (E11) |
| ADP & DMH should change CADDS, CSI, and other systems reporting service data to accept the HIPAA code sets. | The Collaborative HIPAA Implementation Project (CHIP) agreed that CSI and CADDS are not covered under HIPAA. Requiring the same data to be reported with different code sets diminishes the intent of Administrative Simplification. | T6AB |

# 3 Existing Technical Exchange Requiring Revision to Meet HIPAA Compliance

The SD/MC presents complex technical processes involving several different exchange mediums. Claims information is received and sent using modern technologies involving uploads and downloads via the internet, automatic generation of e-mails and software switches to invoke processes between components. Middleware performs server functions using an ORACLE database and traditional file structures are maintained in support of the legacy processing which is used for adjudication.

Data is exchanged using HTTP pages, in binary, in text format, in ASCII and in EBDIC, depending on where the claim is in the process.

The HIPAA TCS Regulations do not require that technical exchanges be made in any manner beyond the types of transactions that can be sent, the transaction formats, data that must be present and code values that must be used. Therefore the existing technical exchange is compliant.

# 4 Data Exchange and Data Set Review

The processes that are in place have successfully performed the Phase I tasks of processing HIPAA transactions, while continuing to support the proprietary system. There is much work to do, however, to make these processes HIPAA compliant as described in the following tables. As indicated in subsections 2.2-2.4, these changes do not have to occur at the current location of the process. There may be decisions that move these processes to different locations (i.e., different applications or systems). The requirements described, as well as the HIPAA-compliant processes currently in place under Phase I must continue wherever the process resides.

## *4.1 Data Exchange Review*

**Table 14 – Data Exchange Review - Systems**

| Data Exchange Review - Systems | | |
|---|---|---|
| **Process Description** | **GAP Description** | **Requirement** |
| ITWS | Receives claims in proprietary format | Discontinue receiving proprietary claims |
| | Posts electronic EOBs as payment advice | Post compliant 835s |
| | Does not receive 276 claim inquiry transactions | Receive and forward 276 transactions |
| | Receives Error Correction file | Discontinue receiving proprietary correction file; support void & resubmittal process through receipt of 837 transactions |
| | Does not post 277 transactions as the claim inquiry response | If 277 is received post for the original submitter of the matching 276 |
| Translator (including Pass-Through Database) | | |
| | Only passes on data fields used in SD/MC; only retains data needed for 835 file creation | Archive full 837 transactions; Pass on all data needed for claim adjudication and other business processes, as well as 835 and 277 file creation. |
| | Creates non-compliant 835 | Discontinue creation of non-compliant 835; create compliant 835s |
| | Does not validate or translate inbound 276 transactions | Validate inbound 276 transactions; translate 276 transactions into format necessary for processing |
| | Does not generate or validate outbound 277 transactions | Generate outbound 277 transactions from internal processing format; validate 277 transactions and forward |

| Data Exchange Review - Systems | | |
|---|---|---|
| **Process Description** | **GAP Description** | **Requirement** |
| | | for posting on ITWS |
| AOD InfoNet | Receives claims in proprietary format from ITWS | Discontinue receiving proprietary claims |
| | Does not receive 837P transactions | Receive 837 |
| TAPS | Stores Summary data of proprietary format | If it is to remain as the data repository for ADP, needs to store all data contained in 837p. Need to store 6 years of all history. Payment history should store all 835 elements and should be able to reconcile all previous codes to HIPAA codes in history. Need ability to receive SCO information after adjudication run. Must be able to reconcile all previous codes to HIPAA codes in history. |
| SD / MC Claim Adjudication | All claims files are in proprietary format | Must be able to process relevant HIPAA data elements, such as multiple diagnosis codes. |
| | Processing uses proprietary service codes | Must use HIPAA data values for such things as procedure and diagnosis |
| | Generates EOBs | Must generate a compliant 835, including payment info |
| | Generates ECRs | Must support Voids and Resubmissions |
| | Maintains Suspense file for error correction | Although suspends are permissible, they should be restricted to circumstances that are not under the submitters control, i.e. support file errors |
| | Does not process 276 claim inquiry transactions | Receive and process 276 transaction data |

| Data Exchange Review - Systems | | |
|---|---|---|
| **Process Description** | **GAP Description** | **Requirement** |
| | Does not create 277 transactions as the claim inquiry response | Collect data for 277 transaction creation based on submitted 276; transmit results to generate and validate a 277 transaction. |
| DHS Key Data Entry | Enter data from paper ECRs to correct electronically submitted proprietary claims. | Redesign ECRs to accommodate HIPAA data and matching with submitted HIPAA claims, or discontinue correcting electronic claims with paper ECRs |

## *4.2 Data Set Review - Inputs*

**Table 15 – Data Set Review - Inputs**

| Data Set Review – Inputs | | |
|---|---|---|
| **File Description** | **GAP Description** | **Requirement** |
| Paper Claims | Proprietary format | Convert to standard forms, however ADP & DMH plan to require electronic input |
| Daily DMH Claims to mainframe process | Proprietary format (157 bytes) | Proprietary format must be replaced with 837p & 837i data |
| Daily ADP Claims to mainframe process | Proprietary format (157 bytes) | Proprietary format must be replaced with 837p & 837i data |
| 837 P format Professional Claims | Limited fields are passed on to the adjudication record. | Increase the number of fields passed on. |
| 837 I format Institutional Claims | Limited fields are passed on to the adjudication record. | Increase the number of fields passed on. |
| ADP 1592 Monthly Invoice Summary | Outside of HIPAA Regulations | No HIPAA requirement; must hold claim adjudication until document received and confirmed or find other alternative. |
| MH1982A Monthly Invoice Summary | Outside of HIPAA Regulations | No HIPAA requirement; must hold claim adjudication until document received and confirmed or find other alternative. |

| Data Set Review – Inputs | | |
|---|---|---|
| **File Description** | **GAP Description** | **Requirement** |
| Correction File from KDE | Corrections are not HIPAA Compliant | Corrections are to be made via void and resubmit 837 transactions |
| Suspense Master File | Errors are not to be suspended, they are to deny | There may be circumstances when suspense is desirable. In this case records should be retained with 837 data instead of in the 350-byte proprietary format |
| Duplicate Check Master File | Uses non-HIPAA Service Codes | Convert to HIPAA Service Codes |
| Medi-Cal Eligibility Data System (MEDS) | Many fields are captured from MEDS, including the MEDS ID, Client Index Number (CIN), Beneficiary Identification Card (BIC) Issue Date, Health Insurance Claim (HIC) Number, Date of Birth month and year, Buy-In Part B Effective Date, Aid Code, and County Code | Discontinue sending back data that was submitted on the claim, unless the internal data is different. Data captured for internal use is not impacted. |
| EOB (as input to TAPS) | The EOB is not HIPAA compliant | This is not required to change due to HIPAA since it is internal, but the EOB may not continue to be supported; replace with compliant 835 |
| Claim Status request | Manual for claims that are in the adjudication process, i.e. have left ITWS | Implement compliant 276 Transaction using submitter control number |
| Pass Through Database | Holds incoming claim data necessary to create non-compliant 835 | Replace with processes that create compliant 835 from adjudicated 837 transaction data and payment information. |
| Payment Information from SCO | The check or EFT number and payment amount are not available to SD/MC processing. | The check or EFT number and payment amount are required for a HIPAA compliant 835 transaction. |

## *4.3 Data Set Review - Outputs*

**Table 16 – Data Set Review – Outputs**

| Data Set Review – Outputs | | |
|---|---|---|
| **File Description** | **GAP Description** | **Requirement** |
| 997 Transaction | Outside of HIPAA Regulations | None |
| 835 'Information Only' Transaction | Not HIPAA compliant | Replace with compliant 835, which includes payment information |
| Electronic EOB | Not HIPAA compliant | Replace with compliant 835 |
| Electronic ECR (ECF) | Not HIPAA compliant | Implement a void and resubmittal process using 837 transactions |
| 277 Transaction | Manual for claims that are in the adjudication process, i.e. have left ITWS | Implement compliant 277 Transaction |
| Suspense Master File | Errors are not to be suspended, they are to deny | There may be circumstances when suspense is desirable. In this case records should be retained with 837 data instead of in the 350-byte proprietary format |

# 5 Technical Operations Requirements

This section presents requirements that have an impact on Technical Operations. Listed are requirements that impact the performance of the SD / MC and those which could affect technical resources.

**Table 17 - Technical Operations Requirements - SD/MC**

| Technical Operations Requirements – SD/MC | | |
|---|---|---|
| **Requirement Description** | **Comment** | **Req. Reference** |
| Approximately 37 counties interact with the system, i.e. provide claims data for ADP. There are about an equal number of Direct Providers | The number of trading partner is not a gap, but a benchmark for processing requirements. | T108 (A1) |
| The system needs to manage the maximum number of claims without a run time impact. System needs to be sized so that projected volumes have no impact. | System needs to be sized so that projected volumes have no impact. 200,000 to 600,000 DMH claims are processed per cutoff period | T309 |
| SD/MC should support the ability for DHS to receive, process and pay all claims directly, if and when it is decided to adjudicate in this manner. (Providers submit directly to DHS and have payment sent directly back to the providers) | | T6AE |
| SD/MC provider file at DHS requires synchronization with the County and DMH provider files. The process: 1) Counties receive a Provider ID from DMH; 2a) Counties certify providers, maintain county provider file and send certification to DMH; 2b) DMH certifies county run providers; 3) DMH activates in DMH provider file and notifies DHS and EDS; 4) DHS activates in the SD/MC; 5) EDS adds to Medi-Cal provider file and sends an authorization letter allowing access to automated eligibility file | The provider file may be impacted depending on the solution alternative selected. | T403 (C6) |
| Adjudicated claim data is downloaded to a server for reporting | The data available for download will change. | T405 |
| The system needs to send paid claims data to the MIS/DSS | The desired format is the Standard 35 file (S035) | T407 |
| System needs to execute in a manner that does not have an adverse impact on payment when processing HIPAA transactions versus other transactions. | SD/MC claim adjudication is executed four times a month with ADP / DMH input. | T3AD (C11) |
| At the completion of processing, DHS notifies ADP / DMH with an e-mail containing Data Set Names (DSN) of the output report / files | | T424 |

| Technical Operations Requirements – SD/MC | | |
|---|---|---|
| **Requirement Description** | **Comment** | **Req. Reference** |
| Updating of diagnostic & procedure codes must occur at HIPAA frequencies, at least quarterly. Run Logs are used by DHS/ITSD Data Guidance Unit to balance program inputs and outputs | User Maintenance consists of manual updates to tables and information used by the SD/MC system including: Federal Share Rates; Diagnostic Codes; Provider Master File; Cutoff Dates; HFP Hold Days; Rate Tables; Run Log | T3AB |
| Most submitters include all of their claims in one transaction. A consistent exception is LA County, who usually submits five transactions | | T440 |
| Utilize Secure FTP to receive and transmit HIPAA transactions. | Current processes require manual interaction. HIPAA security regulations will require a secure transfer mechanism. Secure FTP is only one way to achieve this. | T531 (D17) |

# 6 Staffing

The mandatory changes necessary to meet HIPAA Compliance Requirements are dramatic and necessitate a reworking of the SD/MC Claims Process. The processes that compose SD/MC are spread across ADP, DHS, DMH and HHSDC. This section will not address staffing models impacts due to selecting different solutions, but rather changes that can be identified based on the requirements in this document. All changes indicated will require resources for testing. It is assumed such resources would be from existing staff in addition to any temporary staffing needed. Staffing that is referred to as "permanent" in the table reflect the need for state staff or a long-term contract.

**Table 18 – Staffing Model Impacts Due to Mandatory Requirements**

| Staffing Model Impacts Due to Mandatory Requirements | | |
|---|---|---|
| **Mandatory Major Requirement** | **Implication** | **Staffing Model Impact** |
| Receive compliant 837P, 837I, 276, 277 & 835 Transactions. Discontinue accepting proprietary formats. | Modify the front end processing to receive or post/transmit the listed transactions and reject attempts to use proprietary formats. | Minimal, unless transactions are transmitted instead of, or in addition to, posted. Staffing to manage and monitor the transmission process would be necessary. |
| Validate inbound and outbound transactions for HIPAA compliance. | A permanent process for HIPAA validation must be identified. | Permanent staffing required that can monitor, maintain and update the validation process, as well as consult with business experts as necessary. |
| Discontinue processing proprietary claims. | Shut down processes designed to validate, reformat and track proprietary claims. | Staffing models organized around the proprietary process would need to shift to HIPAA claims processes as appropriate. |
| Use HIPAA data element values, such as Procedure code, Diagnosis, hospital dates, etc. | Major revision to all processing edits, routines and record formats. | Non-permanent staffing to assist in performing revisions, including working with business experts. Depending on the expanded amount of data processing logic that results, permanent staffing increases may be necessary for support. |

| Staffing Model Impacts Due to Mandatory Requirements | | |
|---|---|---|
| **Mandatory Major Requirement** | **Implication** | **Staffing Model Impact** |
| Support updates of the code values used in adjudication to maintain HIPAA Compliance | Develop or acquire a process to receive regular updates and apply them to the system through a regular change cycle process. | Non-permanent staffing to assist in creation or installation of change cycle routines. Create change cycle staffing model with assignment to permanent staffing. Assumes business experts on HIPAA codes currently exist. |
| Install SOC processes | Develop ability to adjust claims based on reported SOC payments. | Non-permanent staffing will likely be needed to support design, development, of and implementation of such logic. |
| Install Provider-to-Payer COB processes | Develop new functionality to adjust processing and pricing and based on COB sent by a provider. | May be sufficiently complex, along with payer-to-payer COB, to necessitate permanent staffing dedicated to this process. |
| Discontinue support of correction process (ECR and ECF) | Shut down processes designed to receive corrections, enter them into the system, and apply them to suspended claims. ECR and DUPECR may continue to be sent out. | Staffing models organized around the correction process would need to shift to HIPAA claims processes as appropriate. |
| Process rendering provider | Develop processing logic to identify the rendering provider and adjudicate claim based on that information to the extent possible. | Non-permanent staffing will likely be needed to support design, development, testing of and implementation of such logic. |
| Obtain payment data from SCO to post to the 835 | Develop functionality to input post-adjudication data, ideally in an automated process | Non-permanent staffing may be needed to establish the process. Permanent staff would need to monitor and maintain the process. |
| Process compliant 276 & 277 Transactions. | Develop processes that will find claims identified per HIPAA criteria, format 277 transactions and return to submitter of the 276. | Non-permanent staffing needed to support design, development, and implementation. |

In addition to the mandatory changes, which are necessary to meet HIPAA Compliance Requirements, are a number of optional requirements. These requirements could result in significant improvements in the efficiency and control of processes, while providing an improvement in the sharing of information.

**Table 19 – Staffing Model Changes Due to Optional Requirements**

| Staffing Model Impacts Due to Optional Requirements | | |
|---|---|---|
| **Optional Major Requirement** | **Implication** | **Staffing Model Impact** |
| Install pre-payment edits for potential fraud / abuse | Develop edits and processes to check incoming and adjudicated claims data to flag suspicious activity. | Non-permanent staffing will likely be needed to support design, development, testing of and implementation of such logic. Permanent staffing would be needed to determine the appropriate criteria and monitor the application of the edits. The extent of the edits may necessitate increased permanent staffing on the technical side. |
| Expand MEDS eligibility edit to access Medi-Cal eligibility verification records | Develop a process to access eligibility verification records from the FI. | This may be a substantial amount of non-permanent staffing to enable this process. Resources at the FI would be necessary as well. |
| Improve timing of the provider update and availability of provider records to the claims process | Revise Claims and Provider update processes so that the most current DMH & ADP provider information is available to claims adjudication. | Non-permanent staffing needed to support design, development, and implementation. |
| Queries of expanded data (six years of all data). | Develop or acquire an application to allow reporting in the manner described. | Non-permanent staffing needed to support design, develop, and implement. New staffing model needed to support such an application. |
| Add automation to the invoice process, keep running totals of contract allocation versus amount paid and report status as soon as adjudication is complete. | Develop ability to track contract amounts as part of the SD/MC process, as well regularly scheduled reports. | Non-permanent staffing needed to support design, develop, and implement. |
| Provide Cost Data reconciliation on a demand basis, (more frequent than annual). | Develop trading partner specific outputs of adjudicated claims data. | Staffing may be needed to handle inquiries from trading partners based on the data they access. |
| Allow providers to bill DHS directly. | Move the receipt, processing, and transmittal of SD/MC HIPAA transactions to DHS. | Staffing models supporting front-end processing and back-end transmittal for SD/MC at ADP and DMH would need to be developed at DHS. |

| Staffing Model Impacts Due to Optional Requirements | | |
|---|---|---|
| **Optional Major Requirement** | **Implication** | **Staffing Model Impact** |
| Support Capitation or other regularly scheduled payment outside of claim process. | Develop functionality to upload financial data not tied to specific claims and incorporate into outbound transactions. | Non-permanent staffing needed to support design, develop, and implement. Existing accounting staffing models may need slight modification. If it is determined and 820 transaction is needed, additional permanent staffing may be appropriate. |
| Payer-to-payer COB | Develop ability to receive and process 837 claims from Medicare and other payers originally submitted by SD/MC providers. Send 835 to original submitter. | It is sufficiently complex to necessitate permanent staffing dedicated to this process. |

Additionally, there was a desired requirement from the county perspective that ADP and DMH reporting systems (CADDS and CSI, respectively) be modified to use HIPAA-compliant codes. These systems are not within the scope of the project, so no elaboration on staffing model impacts is available.

# 7 Graphical Overview of Data and Process Flow

The following graphs presume that readers have basic knowledge of the flows and therefore liberties are taken to present a flow that is clearer than it would be otherwise.

The intent of the graphs is to portray, processing of inputs and outputs displaying data flows that must be removed, ones that must be implemented and flows that may remain unchanged, in order for the SD/MC claims process to be HIPAA Compliant. These graphs are not intended to reflect a suggested solution; use of the current components in the graphs enables easier comprehension of the proposed changes. Some flows that are depicted have not been implemented, such as ADP Corrections (ECF), which are shown as discontinue. This development is a projection, following the DMH ECF, which is in a test phase. Paper claims are not shown, because they are not affected by HIPAA. Invoice documents however, are shown because claims are not released until verified with those documents.

The 276 / 277 process is undefined at this time and is shown here as a mainframe process, with an accompanying expanded history of 837 / 835 records but it is not proposed as a solution.

Batch Balance Information is shown in this chart as an input to AOD InfoNet, rather than as an output of TAPS, because claims move forward only after assignment to in-balance batches. This is also true of the Translator HIPAA edit result, shown as input to ITWS, rather than output of the Translator, because claims with fatal errors are not released.

The Pass Through Database and the 837 Database are shown as an input process, even though they are output files, because at present they have no destination outside of the program that creates them.

The output flow shows one block for manual activities. These activities include verifying that batches are complete, accounting invoice preparation and DHS submission to the SCO. The intent is to show data flow that is affected by HIPAA TCS Regulations and these manual operations are excluded.

Flows from the SD/MC to ITWS and TAPS are depicted as direct when in fact EOB files are produced and downloaded to these systems. The Electronic EOBs are listed as replace but the HIPAA Transaction for replacement has not been determined.

The following diagrams represent the data flows outlined above:

Figure 1 – Data Flow Diagram (Inbound Processes)

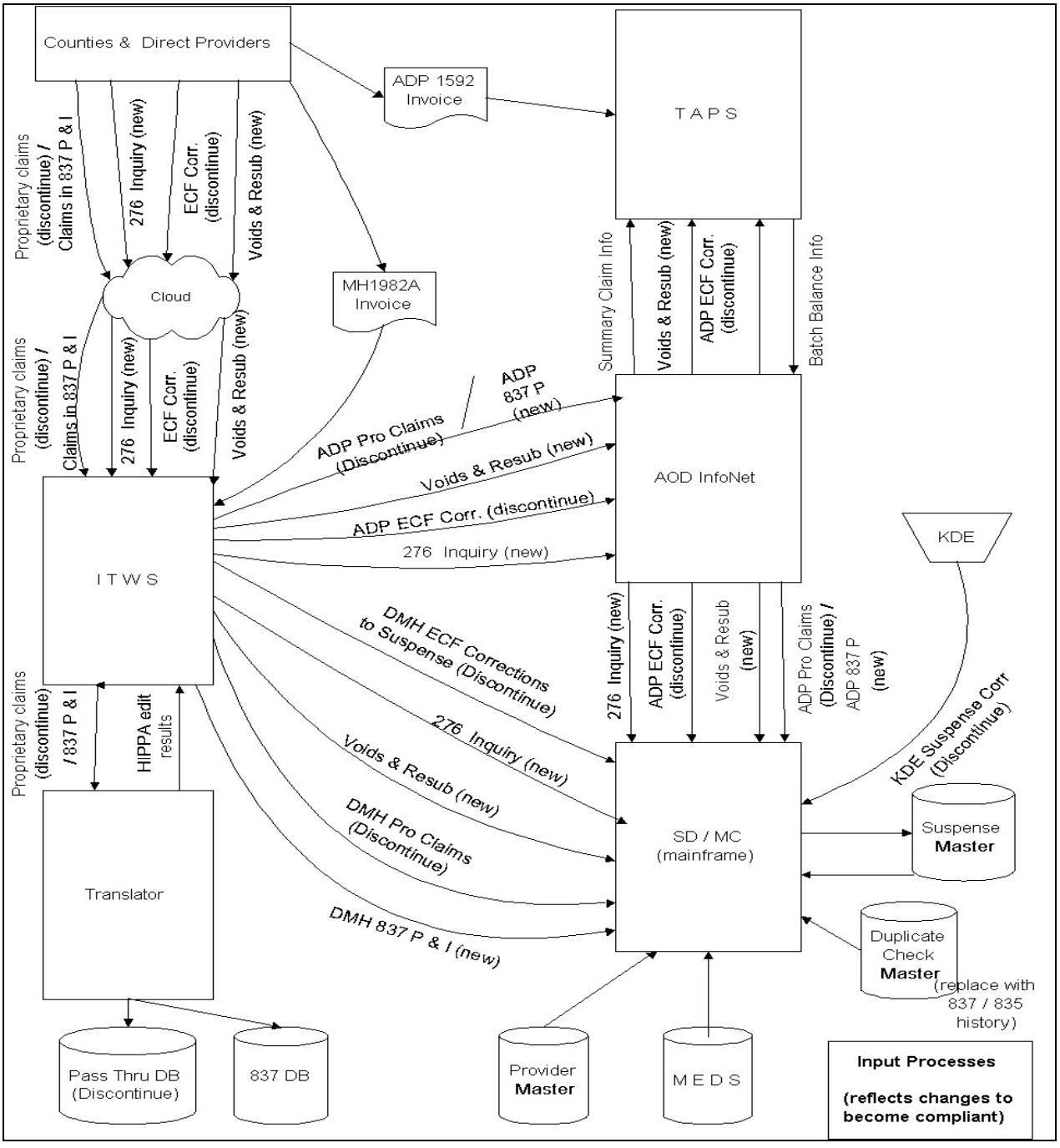
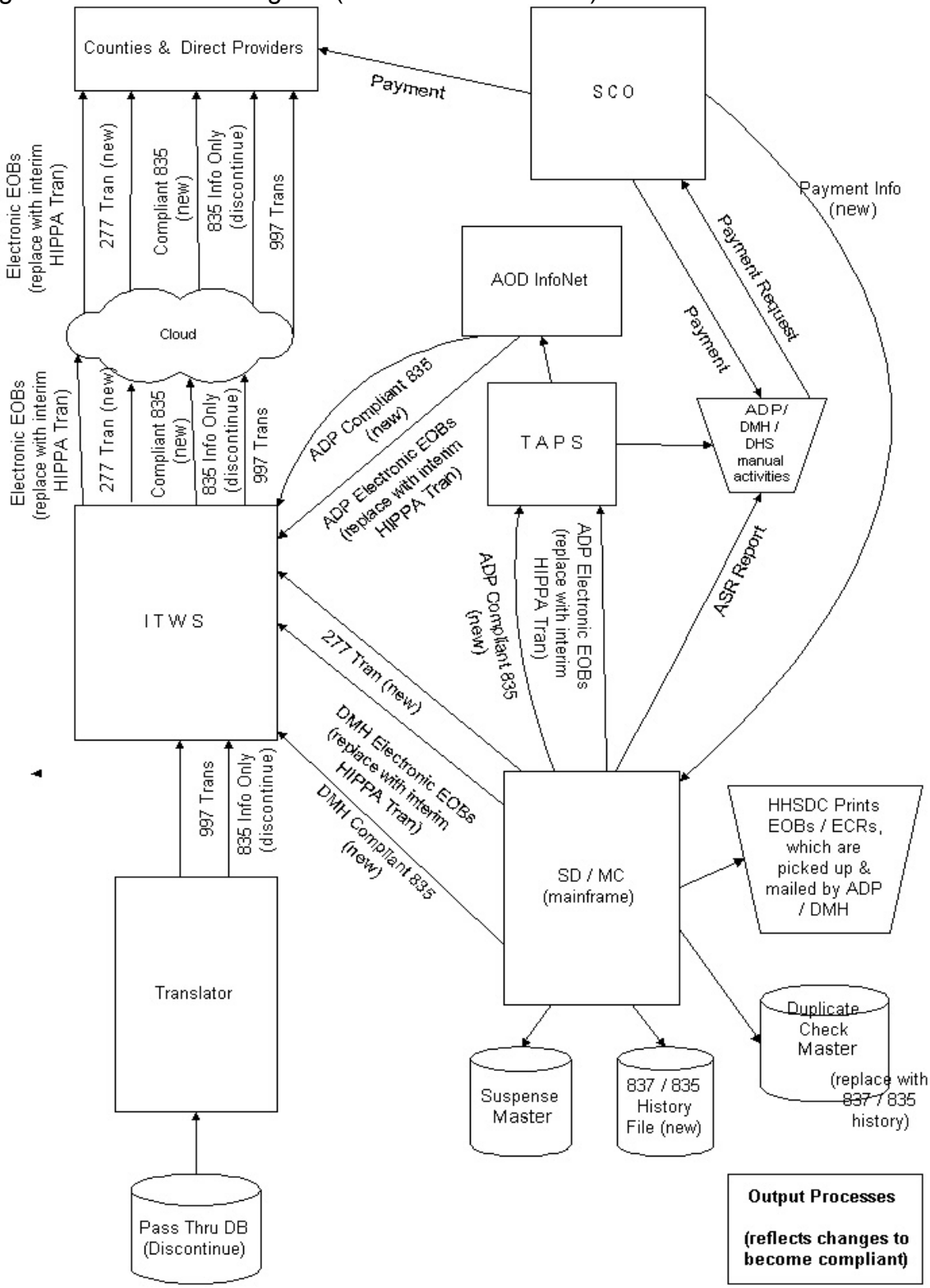


Figure 2 – Data Flow Diagram (Outbound Processes)



# 8 Gap Analysis and Requirements - Technical Requirements Approval

We have reviewed the SD/MC Phase II Gap Analysis and Requirements – Technical Requirement document and hereby approve it.

Signature on File Date 10/25/2004
Karen Redman, Project Director, ADP HIPAA Office

Signature on File Date 10/20/2004
Julie Baltazar, Chief, DMH Office of HIPAA Compliance

Signature on File Date 10/20/2004
Linda Williams, DHS-ITSD-MAS

Signature on File Date 11/15/2004
Russ Hart, Chief, PSD OHC Technology Section